LUSC Soccer Clinic Health Form

Camp Name/Date(s): **LUSC 2024 Clinics**

- ❑ **April Vacation Clinic -** April 16th-18th, Tues-Thurs, 9:00-1:00pm
- ❑ **June Kick off the Summer Clinic -** June 24th-27th, Mon-Thurs, 9:00-12:00pm
- ❑ **Mid-Summer Clinic** - July 15th-18th, Mon-Thurs, 9:00-12:00pm
- ❑ **August Preseason Clinic -** Aug 19th-22nd, Mon-Thurs, 9:00-12:00pm

Every camper needs a completed health form to participate in any summer clinic program. Please fill out this form as completely as possible. Thank you!

SECTION I – BASIC CONTACT INFORMATION

Camper Name_____
LAST FIRST

Birth date_____/_____/_____ Age _____ Gender □ Male □ Female
Home
Address_____
STREET CITY STATE ZIP
Home Phone_____

Parent/Guardian #1 Name_____

Relationship_____

Day Phone_____ Night Phone_____

Day Phone is □ Home □ Work □ Cell Night Phone is □Home □ Work □Cell

Parent/Guardian #2

Name_____

Relationship:_____

Day Phone_____ Night Phone_____

Day Phone is □ Home □ Work □ Cell Night Phone is □Home □ Work □Cell

Additional Emergency Contact_____ Relationship_____
(In case we can't reach YOU)
Day Phone_____ Night Phone_____

Family Physician _____Phone_____

Dentist/Orthodontist Name

_____Phone_____

SECTION II – INSURANCE INFORMATION

Is the camper covered by family medical/hospital insurance? □ Yes □No

If yes, indicate Insurance Carrier_____

Group #_____ Policy #_____

Policy Holder's Name_____

Relationship to participant_____

SECTION III – ALLERGIES

□ Camper does not have any Allergies

Camper is allergic to
□ 1. Hay Fever □ 2. Poison Ivy/Oak □3. Insect Stings □ 4. Food □ 5. Penicillin □ 6. Other Drugs □ 7. Other

List allergy. Describe reaction and treatment

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SECTION IV – IMMUNIZATIONS

Please record the month and year of immunizations. If you do not know the dates or whether camper has had certain immunizations, simply leave blank. You must also bring a COPY FROM YOUR DOCTOR.

DPT (Diphtheria, Pertussis, Tetanus) _____

HIB (Haemophilus Influenza B) _____

Tetanus Booster _____

Tuberculin Test_____

Polio_____

Varicella (Chicken Pox) _____

MMR (Measles, Mumps, Rubella) _____

Hepatitis B_____

SECTION V – HEALTH HISTORY-You can also just attach the PHYSICAL SUMMARY FROM YOUR CHILD'S DOCTOR.

Please know that we value your privacy. Health History information is available only to the camp health staff. The more information you provide, the better we can do our job. Thanks!

Has the camper have a history of or is prone to any of the following (Please check all that apply).

 1. Recent injury, illness or infectious disease
 2. Chronic or recurring illness
 3. Asthma
 4. Homesickness
 5. Frequent Ear Infections
 6. Seizure Disorder or Convulsions
 7. Dizziness during or after exercise
 8. Chest pain during or after exercise
 9. Heart Defect/Disease
 10. Hypertension
11. Bleeding/Clotting Disorders
 12. Diabetes
 13. Mononucleosis (in last 12 months)
 14. Chicken Pox
 15. Measles
 16. German Measles
 17. Mumps
 18. Tuberculosis
 19. Hepatitis
 20. Joint problems (knees, ankles)
 21. Fractures
 22. Frequent Headaches
 23. Head Injury
 24. Eating Disorder
 25. Diarrhea or constipation
 26. Frequent Stomachaches
 27. Wears glasses or contacts
 28. Been Hospitalized
 29. Wears a Medic Alert ID

Please list the number and provide explanation for any checked items

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Date of Last Physical Exam (Required within 18 months of camp)_____

SECTION VI – AUTHORIZATION

My child has permission to engage in all prescribed camp activities except as noted. The information provided on this form is accurate to the best of my knowledge. I have indicated any special health conditions, including required medication and activity limitations which should be known to the camp staff and medical personnel. I am aware of and accept the risk inherent in the program activity. I give consent in advance for medical treatment at an appropriate facility in case of illness or injury.

Signature of Parent or Guardian X_____

Printed Name_____

Date_____